legislation, and there was objection to the unanimous consent to move it forward.

For the week, that is stall tactic No. 7.

What will next week hold? We are going to conclude PNTR on a vote on Tuesday, I believe. We have numerous appropriations bills that ought to be dealt with. Hopefully, we can and will deal with them and in doing so pick up the pace around here and get our work done so that we can adjourn—so that we can send a very clear message to the American people of the intent of this Congress to balance the budget; to hold sacred the Social Security surplus; to make sure that we deal with health care in a responsible way for our citizens; hopefully that we could give back a few of these surplus tax dollars, but if we can't do that, at least dedicate a large portion of it to debt buydown so that young people in their lifetime won't have to finance the debt structure of the generation before them.

Those are responsible and right things to do, and I hope we can do them. But I will be back next week to talk probably about stall tactic No. 8, No. 9, No. 10, and No. 11. At least I am going to until the minority leader comes to the floor and he recants and says that he didn't say this or that this isn't a strategy because if it is a strategy, it is bad politics, and it is darned bad government to simply say, no, we are not going to work until we get the right to spend billions and billions of dollars of more money. That is not bipartisan. Most importantly, that is bad policy.

Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

Mr. CRAIG. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

MORNING BUSINESS

Mr. CRAIG. Mr. President, I ask unanimous consent that there now be a period for the transaction of routine morning business with Senators permitted to speak for up to 10 minutes each.

The PRESIDING OFFICER. Without objection, it is so ordered.

PRESCRIPTION DRUGS AND PREVENTIVE CARE: THE KEY TO TRUE MEDICARE REFORM

Mr. GRAHAM. Mr. President, yesterday I started the first of what will be five or more brief statements on issues related to the subject of the Federal Government providing a prescription medication benefit to Medicare recipients.

Yesterday, I opened this series with a discussion of what I consider to be the most important reform required in the Medicare system; and that is reforming a 35-year-old health care system which was established to provide acute care; that is, care after an illness had matured into a major condition, or after an accident had caused a person to require specific medical attention largely in a hospital setting.

What was not included as part of the 1965 Medicare program was an emphasis on what seniors want today; and that is, they want a system that will not just treat them after they are seriously ill but to have treatment that will avoid or reduce the impact of those illnesses through effective preventive strategies.

Those preventive strategies have many components, including regular screenings for those conditions that can be detected at an early time; and then the management, through a variety of sources, of those chronic conditions so that they do not mature into serious health concerns, in some cases even death.

To me, the conversion of Medicare from a sickness program to a wellness program is the fundamental reform that this Congress must achieve.

If we are going to have this new orientation on wellness, prescription drugs will play a critical role. Prescription drugs are a part of almost every methodology of managing a medical condition which, if not appropriately managed, could mature into serious complications. Prescription drugs are a key to providing true quality preventive care for our senior citizens.

My point is illustrated by an example.

Mrs. Jones is a Medicare beneficiary. She has, like an increasingly large number of Medicare beneficiaries, no drug coverage. Unfortunately, Mrs. Jones also has diabetes, hypertension, and high cholesterol. These are three conditions which in the past would have been debilitating, even fatal. Today, thanks to the miracle of modern medicine, Mrs. Jones can treat these conditions and continue to live a healthy life.

Mrs. Jones is likely to be treated with Glucopahge, Procardia XL, and Lipitor.

The annual cost of Glucophage will be $708. The annual cost for Procardia XL will be approximately $500 to $900, depending on whether 30 or 60 milligram tablets are prescribed. The annual cost of Lipitor is approximately $700. The total annual spending for these three drugs alone for Mrs. Jones will range between $1,900 and $2,300. These costs, for most seniors—I would argue, for most Americans—are likely to cause significant economic hardship. But if Mrs. Jones does not take these drugs, she will find her conditions raging out of control and will surely be a candidate for expensive hospital stays and surgery.

Those last two comments underscore the fact that this is a medical issue in terms of will we make available and affordable to our older citizens those drugs which are available to manage conditions and avoid those conditions maturing into the need for expensive hospitalization, surgery, or even conditions that are beyond the ability of those heroic measures to stop the unending pace towards death. It is also an economic issue.

For most seniors, there are many years of preparation for retirement, preparation which is particularly oriented to assure that there will be an economic foundation under their retirement years. There are many challenges and risks to that economic foundation. Today the most prominent of those risks, the one which is most feared by millions of older Americans, is the fact that they will, in fact, be diagnosed as having some condition which, the good news is, is treatable and controllable. The bad news is, it will wreck their economic foundation to pay the cost of those drugs. We are dealing not only with an issue of medical humanity but also of economic security. We owe it to our Nation's seniors that they have the chance to live a full, healthy, and economically secure life in retirement. Prescription medications are a key to allowing them to do so.

When Medicare was established in 1965, Mrs. Jones may have benefited most by a system that provided effective hospital care, that did not have a particular focus on preventive benefits, where outpatient prescription drug coverage was not a particularly significant factor. But in the 35 years since that time, medical science and our set of values of what we want from our health care system have changed dramatically.

Today pharmaceuticals, not surgery, are the first line of defense against illnesses. The number of prescriptions for American seniors grew from 648 million as recently as 1992 to more than 1 billion in the year 2000. One example of this transition from surgery to pharmaceuticals is the treatment of ulcers. It used to be that the standard treatment was surgery. Today surgery for ulcers is a very rare event. What has happened is the substitution of effective pharmaceuticals to treat, remedy, and reverse ulcerous conditions.

A senior is better because he or she has avoided the necessity of intrusive surgery. Our taxpayers are better because they have avoided the cost of that surgery, and the senior is able to resume a normal quality of life.

We should think of preventive medication today as the anesthesiology of the last century. I have suggested that if Medicare had been created, not in 1965 but at the end of the Civil War in 1865, there would have been the same debate that we are having today over whether we should include anesthesiology. As we know from our study of Civil War history, it was not uncommon for very serious surgical procedures to be conducted without anesthesiology. Today we would think it to be